STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE & ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

Phil Bredesen
Governor

M.D. Goetz, Jr.
Commissioner

October 6, 2005

The Honorable Phil Bredesen
Governor
Tennessee State Capitol
Nashville, Tennessee 37243

Dear Governor Bredesen:

I am writing to share good news. Based on early claims reports, our continued efforts to control growth in pharmacy have put TennCare on track to reduce total pharmaceutical expenditures by $1 billion in this fiscal year, as necessary to meet our current budget targets.

Early pharmacy savings

As you know from the first McKinsey report in 2004, restructuring the TennCare program relies heavily on our ability to control what have been unsustainable rates of growth in pharmacy. As our fastest growing service area, nearly 50 percent of the program's unreformed growth was due to pharmacy costs. Last fiscal year alone the TennCare program paid $2.4 billion total dollars in pharmacy for 42 million prescriptions.

This positive pharmacy news is attributable to factors beyond just the disenrollment and monthly prescription limits. Since placing our managed care network at risk for pharmacy utilization and since obtaining relief from the Grier consent decree some three months ago, generic utilization numbers have increased five percentage points, which I expect to translate to a total savings of nearly $24 million state and federal dollars this year alone.

During this time period, the Bureau has thoroughly reviewed and reworked the statewide preferred drug list to take advantage of lower prices available through the multi-state purchasing pool. As part of this process, we have significantly expanded the number of managed drug classes to capture a higher percentage of available supplemental rebate revenue from manufacturers. These efforts have been reinforced by aggressive day-to-day management, including the implementation of dozens of point-of-sale edits in our live pharmacy database. These electronic software changes "red flag" inappropriate utilization, and now, thanks to Grier relief, are capable of producing truly meaningful cost and quality control. The TennCare pharmacy program has saved more than $25 million per month in state and federal dollars over the past several months as a direct result of these point-of-sale edits.

In addition, recent pharmacy reports indicate the annual per member per month growth trends have been reduced from 25 percent to less than 10 percent. I expect these results to continue to improve as the year progresses and we transition away from additional Grier restrictions; however, it is noteworthy that, for the first time since this consent decree went into effect, the program is beginning to achieve sustainable levels of pharmacy growth.

Reduction in abusive utilization

Much of this recent improvement can be attributed to the reduction in abusive utilization patterns. For example, the number of enrollees who have been "locked in" to a single pharmacy is at an all time high. Thanks to more aggressive retrospective drug utilization review and data mining activities for key indicators of possible fraud (e.g., individuals with unusually high number of unique prescriptions, inordinate number of transportation services used, high frequency of emergency room visits), nearly 3,100 enrollees are currently locked in – a 1,700 percent increase since July 2004.

As we have discussed, abusive enrollees are responsible for grossly disproportionate costs. As requested, let me review the recent utilization patterns of 10 individuals recently locked-in based on behavior that occurred prior to the implementation of these point-of-sale edits. These particular 10 individuals made claims against the Bureau worth an average of nearly $1 million per year, with nearly 20,000 claims generated between 2000 and 2004. Of course, not all of these claims were paid by the Bureau. Just one of these 10 enrollees received more than a 250 day supply of schedule II and III DEA class narcotics from 11 different pharmacies *in a single month* during 2004. Not surprisingly, in that same year this individual had 25 ambulance trips with diagnoses of coma or stupor and 29 separate emergency room visits for headaches and pains indicative of drug-seeking behavior.

Combined with our new point-of-sale edits, this critical adjustment is already resulting in a tangible reduction in utilization rates of several drugs of interest. In particular, use of hydrocodone has been reduced by nearly 20 percent in the first fiscal quarter. Unfortunately,

this highly addictive and common street narcotic remains our most popular prescription medication by claims volume.

Looking ahead

Despite these successes, I have become increasingly concerned with that minority of enrollees with multiple co-morbidities, especially among our elderly population. This concern has been reinforced through my conversations with physician representatives from the Tennessee Medical Association and Vanderbilt University Hospital, and most importantly, through personal conversations with individual enrollees struggling with multi-drug regimens.

As a result of these conversations and my personal clinical reviews of pharmacy utilization shifts since the implementation of the prescription limit, I recommend that we add a number of additional generic medications to the short list to address three common, chronic disease states:

- Diabetes (insulin; oral diabetes agents)
- Asthma (albuterol inhalers and nebulizers)
- Cardiovascular disease (ACE Inhibitors; Beta Blockers; Diuretics; Calcium channel blockers)

As with all drugs included on the short list, these medications would be available to all enrollees regardless of benefit limits.

To date we have limited the short list to drugs used in the treatment of a small subset of serious diseases where multi-drug therapy is the rule, such as HIV, tuberculosis and hepatitis; however, given our progress in pharmacy reforms thus far, I believe these additions to be an appropriate evolution to address three of our most common causes of morbidity and mortality in the state. With an estimated state cost of $7 to 10 million, I anticipate that this expansion can be funded within TennCare's existing budget, without any additional appropriation or reduction in reserves.

Sincerely,

J. D. Hickey
Deputy Commissioner

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